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Death and Resistance: Professionals on the Front Line Against COVID-19

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Abstract: The COVID-19 pandemic has intensely affected the quality of life and labor conditions of healthcare workers (HCWs). This study sought to understand the experiences of 16 professionals in medicine, nursing and physical therapy who work on the "frontline" of the new Coronavirus. A phenomenological design was used. Results were organized into four axes: (a) the impact of the arrival of the pandemic; (b) participants' progressive exhaustion; (c) fear and coping; and (d) rethinking life and death. Experiences of anguish, anxiety, depression, and physical and psychological health problems stand out. It was possible to observe that the lack of national coordination, in addition to unscientific political positions, were felt as an aggravating factor for work demands, and that impotence in the face of the disease implicated in rethinking the meaning of life and death. According to the JD-R model, the need to expand resources and emotional support so HCWs can properly manage psychosocial risk factors at work is evident.

Keywords: occupational health, stress, public health, hospital administration, phenomenology

Morte e Resistência: Profissionais na Linha de Frente Contra a Covid-19

Resumo: A pandemia vem afetando intensamente a qualidade de vida e condições laborais dos trabalhadores da saúde (TS). Este estudo teve por objetivo compreender as vivências de 16 profissionais da medicina, enfermagem e fisioterapia que atuam na "linha de frente" do novo coronavírus. Empregou-se desenho fenomenológico. Os resultados foram organizados em quatro eixos: (a) o impacto da chegada; (b) desgaste progressivo; (c) medo e enfrentamento e (d) repensando a morte e a vida. Destacam-se vivências de angústia, ansiedade, depressão, agravos à saúde física e psicológica. Foi possível observar que a falta de coordenação nacional somada a posicionamentos políticos anticientíficos foi sentida como agravante das demandas laborais e que a impotência diante da doença implicou repensar o sentido da vida e da morte. Com base no modelo JD-R, fica evidente a necessidade de ampliar recursos e suporte emocional aos TS a fim de administrar adequadamente os Fatores Psicossociais de Risco no Trabalho.

Palavras-chave: saúde ocupacional, stress, saúde pública, administração hospitalar, fenomenologia

Muerte y Resistencia: Profesionales de Primera Línea Contra el Covid-19

Resumen: La pandemia ha afectado intensamente la calidad de vida y condiciones laborales de los trabajadores de la salud (TS). Este estudio buscó conocer experiencias de 16 profesionales de medicina, enfermería y fisioterapia que trabajan en la "primera línea" del nuevo coronavirus. Se utilizó diseño fenomenológico. Los resultados se organizaron en: (a) el impacto de la llegada; (b) desgaste progresivo; (c) miedo y confrontación; y (d) repensar la muerte y la vida. Se destacan experiencias de angustia, ansiedad, depresión, problemas de salud física y psicológica. Se observó que la falta de coordinación nacional, sumada a posiciones políticas acientíficas, fue un agravante de demandas laborales y que la impotencia frente a la enfermedad implicaba repensar el sentido de la vida y la muerte. Desde el modelo JD-R, es evidente la necesidad de ampliar recursos y apoyo emocional a los TS para gestionar adecuadamente los Factores de Riesgo Psicosocial en el Trabajo.

Palabras clave: salud ocupacional, estrés, salud pública, administración hospitalaria, fenomenología

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The new Coronavirus pandemic has profoundly affected the world of work, impacting millions of people globally. Amidst an unprecedented health crisis and its subsequent social and economic impacts, healthcare workers (HCWs) require special attention due to both their proximity to the large number of patients, family members or co-workers'

cases and deaths and the significant changes to their lives and personal well-being.

Among possible tools to understand this phenomenon, Psychosociology of Work (Borges, Barbosa, & Guimarães, 2021) and the job demands-resources model (JD-R) (Bakker & Demerouti, 2007) guide this study. Psychosociology of Work analyzes psychosocial risk factors at work (PRFW), which encompass work content, load and rhythm, schedule, control, environment, equipment, organizational culture, interpersonal relationships, clarity of roles, career, and home-work interface (Leka & Cox, 2008). On the other hand, via the JD-R model, one can understand the quality of the relation between work demands, resources, and their respective outcomes, and how they compromise health services when unbalanced or engage them when appropriate.

Bakker and Demerouti (2007) claim that work demands encompass physical, psychological, social, and organizational factors, whereas, considering these dimensions, work resources relate to what can be functional in achieving work objectives. Mojtahedzadeh, Wirth, Nienhaus, Harth, and Mache (2021) found that, amidst the pandemic, German outpatient caregivers' main demands related to work organization and quantity, tools, tasks, environment, and social and emotional relationships. In turn, the authors found team spirit, communication, information, and recognition to be important work resources.

The first cases of contamination by the new Coronavirus appeared in China at the end of 2019 and, by the beginning of 2020, the disease had not yet spread around the world. In March 2020, however, while the World Health Organization – WHO attested to a global pandemic, COVID-19 caused its first fatality in São Paulo, Brazil. Contagion rates and adoption of sanitary measures, especially social isolation, varied across countries. This scenario included an infodemic marked by a profusion of information which merged reliable sources, fake news, materials of varied quality, and efforts to synthesize technical references, such as the guide organized by the Pan American Health Organization [PAHO] (2020).

Thus, problems related to work balance – personal life, economic stressors, work overload, and HCWs' emotional demands became even more pronounced, even though they began to gain greater social prestige and be applauded in many cities (Rigotti et al., 2021). In Brazil, pandemic management is entangled with political issues that led to three health ministers being replaced during the first year of the pandemic. The first two were physicians who diverged from government stances which defended early treatment and repeatedly attacked scientific institutions (Fernandes, Oliveira, Campos, & Coimbra, 2020).

In response to the restriction of federal data on the evolution of COVID-19, professionals from six media outlets organized a consortium to disseminate daily balances to the population. Teixeira et al. (2020) warn of damage risks to HCWs' quality of life due to a permanent crisis caused by neoliberal practices and the dismantling of the SUS (the Brazilian Unified Health System) by lack of investments.

The effects of the pandemic have been extensively researched around the world, including those impacting healthcare workers. The literature shows a prevalence of acute stress disorder, anxiety, burnout, depression, and post-traumatic stress disorder – PTSD among this population (Arafa, Mohammed, Mahmoud, Elshazley, & Ewis, 2020; Ardebili et al., 2020; Bennett, Noble, Johnston, Jones, & Hunter, 2020; Britt et al., 2021; Buselli et al., 2020; Duarte et al., 2020; Franklin & Gkiouleka, 2021; Giménez-Espert, Prado-Gascó, & Soto-Rubio, 2020; Liu et al., 2020; Mojtahedzadeh et al., 2021; Prescott et al., 2020; Sheraton et al., 2020; Zhang et al., 2020).

These conditions are associated with lack of social support and occupational risks, such as working in environments with a high risk of contagion and lack of specialized training, for example. Sheraton et al. (2020) found anxiety, depression, occupational stress, PTSD, and insomnia among healthcare providers, the latter being more significant in them than in workers of other fields. Franklin and Gkiouleka (2021) were even more specific, defining four sources of psychosocial risks, namely: (a) personal protective equipment - PPE; (b) job content; (c) work organization, and (d) social context. Based on the JD-R model, Britt et al. (2021) consider that COVID-19 may be aggravating systemic problems in the American health system which HCW teams could more easily manage in situations without a pandemic.

Buselli et al. (2020), in a study with 265 HCWs from a hospital in Italy, found higher levels of secondary trauma in women and an association between these levels, burnout, and professional or personal variables with depression or anxiety. Arafa et al. (2020) found symptoms of depression, anxiety, stress, and sleep problems in a population of 426 HCWs from Egypt and Saudi Arabia. Aggravating factors include watching or reading the news on COVID-19 for more than two hours, working in shifts, and lacking social support. Duarte et al. (2020) found, in a 2008 sample of Portuguese HCWs, that health problems and direct contact with infected patients were significantly associated with the possibility of burnout.

Giménez-Espert et al. (2020) observed that the most prominent risk factors among 92 nurses from hospitals in Valencia, Spain relate to emotional work and work load. In England, a survey with 158 HCWs shows that they recognize the efforts the hospitals in which they work make to provide relevant information based on the English public health agency and the WHO, but still felt unsafe when collecting and handling diagnostic samples (Prescott et al., 2020).

Zhang et al. (2020) found that, in addition to greater experience relating to less tiredness, HCWs feared contracting the virus and transmitting it to family members, and felt discomfort with PPE. Work overload, however, can increase the risk of contamination. In a study by Mojtahedzadeh et al. (2021), German outpatient caregivers showed depressive symptoms and feelings of stress due to the imbalance between work demands and resources which were impacted by the characteristics of the pandemic.

Supported by an anonymous email address, 54 UK HCWs shared testimonials that were organized into four thematic groups: (a) shock of the virus; (b) team sacrifice and dedication; (c) collateral damage ranging from personal health concerns to the long-term impact on, and care of, discharged patients; and (d) a hierarchy of power and inequality within the healthcare system (NHS) (Bennett et al., 2020). Liu et al. (2020) conducted interviews with nine nurses and four Chinese physicians whose content analysis produced the following categories: (a) responsibility for patients/"my mission"; (b) challenges of Coronavirus wards; and (c) resilience.

Thematic analysis of interviews conducted with 97 Iranian HCWs found: (a) working in the pandemic era; (b) changes in personal life and enhanced negative affect; (c) gaining experience, normalization and adaptation to the pandemic; and (d) mental health considerations. Thus, the authors could analyze how HCWs' psychological suffering progressed along the stages of their exposure to the pandemic (Ardebili et al., 2020).

Pandemics, such as the COVID-19 one, involve a dramatic number of deaths: almost four million around the world; of which, more than 500,000 took place in Brazil by the end of the first half of 2021. Death is an existential theme that has gained new relevance in people's everyday lives since it became a daily topic in news reports around the world, drawing attention not only for its statistics but also for how it began to happen. According to Coe (2019), for death to take place in a dignified and meaningful manner, it requires care that includes family members, adequate conditions, and professional staff.

However, impositions set by the pandemic generated challenges that prevent HCWs from caring for ill and dying patients as they would like, at least at first. The suffering Benn (2017) described illustrates nursing professionals' desire to humanely deal with this process. Thus, coping strategies (Granek, Barrera, Scheinemann, & Bartels, 2016) and the need for psychological support for HCWs (Schmidt, Crepaldi, Bolze, Neiva-Silva, & Demenech, 2020) are even more relevant now.

As it is constituted, the context of the pandemic becomes even more complex and ambiguous regarding the control and management of the disease due to the scarcity of references that enable the analysis of phenomena of similar magnitude. Since labor demands specifically arising from the pandemic need to be managed (Bakker & Demerouti, 2007; Mojtahedzadeh et al., 2021), the relevance of this study stems from the risk of damage to HCWs' health and quality of life, a group that has experienced the imbalance between high work demands and low resources for more than a year. Thus, this study aimed to understand the experiences of 16 medicine, nursing, and physical therapy professionals who work in the "front line" of the new Coronavirus.

Method

In this to understand the nature of a phenomenon. Via our intersubjective relationship with them, the patterns and meanings of participants' experiences were identified by this co-creation qualitative and exploratory study, comprehensive narratives were written so we could grasp healthcare workers' experiences. This is a Husserlian phenomenological investigation that aims process. Originally, the resource comprises dialogical meetings between researchers and participants, in a climate of empathy and openness, which were initiated by a guiding question. As interaction is emphasized as the source of knowledge, we purposely did not record the interviews (Brisola, Cury, & Davidson, 2017). Their narrative content was individually shown to participants to ensure that their meaning was properly understood.

Participants

Our group consisted of a convenience sample of healthcare providers who work in the two hospitals surveyed. It consists of four physicians, four nurses, four nursing technicians, and four physical therapists, 56% of which were female (n = 9), aged between 25 and 51 years (M = 37.9), with an average work experience ranging from 1.2 to 25 years (M = 12.3). Regarding marital status, 69% were either married, in common-law marriages or widowed (n = 11), and most (90%) had children.

Procedures

Research in the hospitals took place at different times due to the approval periods of the respective Ethics Committees on Research with Human Beings of the Universidade Católica Dom Bosco and of the Pontifícia Universidade Católica de Campinas. Dialogical meetings were held between October 2020 and January 2021 at the hospital in the state of Mato Grosso do Sul and between January and May 2021 at the one in the state of São Paulo. Contact was made via email or WhatsApp and, as a rule, meetings had to be rescheduled many times before they could actually take place due to participants' work overload.

Data collection. In total, 16 individual dialogical meetings were held by videoconferencing (via Google Meet or WhatsApp video calls), lasting, on average, for one hour. After participants understood the ethical and technical aspects of our research, the following question was asked: "How is working amidst the COVID-19 pandemic?" Following participants' answers, new questions were asked so their experiences could be better understood. At the end of the meetings, participants were asked to choose a pseudonym, i.e., "something or someone who represents you in relation to this theme." What their experiences meant was also explored, contributing to the general understanding of our research.

Immediately after the meetings, individual first-person narratives were written, in which we aimed to appreciate participants' experiences by recording their most significant elements. Each narrative was validated by their subject in a second synchronous meeting or asynchronous contact, ensuring bias control and information quality.

Data analysis. Finally, a narrative synthesis describing the structural elements of the phenomenon as a whole was

elaborated by a second researcher and validated with the responsible for the meetings to provide another layer of bias control and refine our results.

Ethical Considerations

This study was approved by the Ethics Committees on Research with Human Beings of the Universidade Católica Dom Bosco and of the Pontifícia Universidade Católica de Campinas. Protocols CAAE 33696820.9.0000.5162 and CAAE 36729320.3.0000.5481.

Results and Discussion

To ensure that we understood participants' experiences, we sought a multidisciplinary group with diverse gender functions and representativeness. Our inclusion criteria were: (a) a healthcare occupation (physicians, nurses, physical therapists, technicians or nursing assistants; and (b) availability to participate in a dialogical meeting during the research period and in a second contact for content validation. Among the 30 potential participants contacted, 16 met our inclusion criteria, as Table 1 shows.

Table 1
Participants' characterization

Pseudonym	Category	Gender*	MS**	Age	Children	EP***	State
Butterfly	Physician	F	Married	50	2	24	MS
Learning	Nurse	F	Widow	51	2	20	MS
Father of three	Physician	M	Married	42	3	18	MS
Antonio Guimarães	Nursing assistant	M	Married	50	4	17	MS
Ribeiro	Nursing technician	F	Married	35	3	10	MS
Dionísio	Nurse	M	Single	48	4	10	MS
Care	Physical therapist	M	Common-law marriage	39	0	18	MS
Horsewoman of the Apocalypse	Physical therapist	F	Single	29	0	6	MS
Scared hero	Physician	M	Married	43	1	10	SP
Vitória	Physician	F	Married	50	0	25	SP
Empathy	Nursing technician	M	Married	31	2	7	SP
Beach	Nurse	F	Single	32	0	8	SP
Orchid	Nurse	M	Single	26	0	1.5	SP
Juliete	Nursing technician	F	Married	30	2	8	SP
Tiane	Physical therapist	F	Single	26	0	3	SP
Wolf	Physical therapist	F	Single	25	0	1.2	SP

Note. *Gender; **Marital status; ***Experience in the position. Prepared by the authors, 2021.

The set of individual narratives produced consists of more than 50 pages of content, full of experiences which were often emotionally shared. The researchers read and reread this material in depth to identify the structuring elements of the phenomenon studied (Brisola et al., 2017); a strategy similar to the ones in Ardebili et al. (2020), Bennett et al. (2020), and Liu et al. (2020).

Thus, the following axes emerged: (a) the impact of the arrival of the pandemic; (b) participants' progressive exhaustion; (c) fear and coping; and (d) rethinking life and death. In general, regardless of participants' residence or specialty, their experiences show many common elements. We found no relevant differences between genders, contradicting studies that suggest women began to suffer more from overload (Arafa et al., 2020; Buselli et al., 2020).

The impact of the arrival of the pandemic: it looked like a horror movie!

In general, reactions to the guiding question were quite uniform; loaded with expressions such as "challenging!" or "a very tense process," similar to English physicians and nurses' experiences of "feeling broken" or "the horror that is COVID-19" (Bennett et al., 2020). After a brief calmness mixed with concern, such as when one observes the change in weather preceding a storm, participants saw the arrival of the pandemic as a battle to which they were summoned, as in Liu et al. (2020). They felt a fearful heroism: "I'll be useful, I'll be able to help!" thought one of the physical therapists.

At first, insufficient facilities and equipment, especially PPE, were critical issues that required an immediate reaction from hospitals. Entire wings were created to treat COVID-19,

and functions of whole teams were redirected, bothering HCWs. Ardebili et al. (2020) and Liu et al. (2020) also report that spaces which were not previously reserved to treat infectious diseases were rapidly transformed into COVID wards, and that health teams lacked adequate equipment and felt discomfort with the necessary apparel.

As in Bennett et al. (2020), our participants were concerned with areas which were left unassisted, such as care for chronic patients or accident victims, for example. This whole scenario significantly worsened psychosocial risk factors at work (Leka & Cox, 2008) because it abruptly and intensely unbalanced the relation between work demands and resources, causing suffering to both HCWs and patients' relatives. Britt et al. (2021) found that, in epidemics, PPE supply and colleague and institutional support are essential resources to reduce HCWs' tension.

The high lethality rate of the pandemic, associated with the lack of an effective vaccine during its first year, caused insecurity and exhaustion, even in cases in which HCWs recognized the care taken with the available information (Prescott et al., 2020; Zhang et al., 2020). One physician reported feeling "as if I had just graduated and in my first residence year," whereas her colleague stated that "even the simplest things seemed threatening" (Physician).

There were reports of embarrassment among hospital professionals regarding the use of masks since those who wore them were considered overzealous at first. "I'm the only one walking like an astronaut in the hospital! They ask me if I don't have any faith!" (Nurse). Similarly, both HCWs and one of the hospitals studied showed divergent behavior, in which they refrained from wearing masks to avoid "stressing patients."

Arafa et al. (2020) argue that governments and the WHO should make a greater effort to promote adequate information and curb the dissemination of incorrect content about COVID-19 on social media and television. However, the opposite took place in Brazil. Lack of accurate and adequate information exacerbated tensions in our health team, and the news published by the media "caused more apprehension than guidance," according to one of the physicians we heard, showing evidence of the deleterious effects of the infodemic.

Note that guides such as the one published by PAHO (2020) were yet unavailable at the time, and the Brazilian President had repeatedly criticized social distancing and the isolation measures adopted by governors, which he deemed "exaggerated" (Fernandes et al., 2020). One nurse stated that she felt like "an inadequately used tool," and a nursing technician found that "results only improved when the hospital began to adopt its own conduct protocol, irrespective of Ministry of Health recommendations," which is very serious.

A physician expressed feeling sorry for rulers, because "no one knew what to do then." Others, however, were more critical in their comments, especially on the politicization of the disease, and lack of support and federal articulation. This type of discomfort is consistent with the outburst of a British nurse who stated that "the government failed us all" (Bennett, 2020 p. 5) and the criticism in Teixeira et al. (2020). Public health policies and national decision-making are contextual collective factors which can directly affect risk perception and exhaust resources to cope with work demands.

Progressive exhaustion: I cannot stand beating a dead horse anymore!

Their feeling of heroism gradually gave way to frustration and tiredness. Experiences began to have a chronic character, especially regarding exhaustion, consistent with the progression described by Ardebili et al. (2020), which ranged, in the early stages of exposure, from fear, anxiety and a feeling of loss of control to long-term results such as depression and PTSD.

Since our meetings took place between the end of the second and the beginning of the third semester of the pandemic, they seem aligned with the crisis peak and with symptoms of helplessness, hopelessness, and depression. One physical therapist vented: "I can't stand beating a dead horse anymore" and one physician said, "Then, I stuff myself with antidepressants and I don't know when and if this is going to end." In addition to psychological suffering, these statements reflect a concern for the future, which Ardebili et al. (2020) also observed.

In general, participants reported that their insecurity and anxiety gradually decreased: "I was alert 24 hours a day, always tense" (Nurse), and were replaced by exhaustion: "The next day is the same thing… I come home exhausted" (Physician). To mitigate these kinds of effects, Britt et al. (2021) highlight the need to understand which work resources and demands are at stake to protect HCWs, in line with the models in Bakker and Demerouti (2007), Borges et al. (2021), and Leka and Cox (2008).

Guilt, irritability, stress, impotence, anguish, anxiety, and extreme tiredness were also frequently cited. Results which agree with the findings of systematic reviews (Franklin & Gkiouleka, 2020; Sheraton et al., 2020) and of empirical studies (Arafa et al., 2020; Ardebili et al., 2020; Buselli et al., 2020; Duarte et al., 2020; Liu et al., 2020).

Schmidt et al. (2020) and Teixeira et al. (2020) express concern about this type of suffering in HCWs and highlight the importance of offering resources for adequate care. According to Zhang et al. (2020), professionals with greater overburden tend to wash their hands less often, raising contagion risks, which, in this case, may be lethal.

Most participants expressed discomfort and indignation with how a portion of society showed lack of care by participating in agglomerations or refusing to wear masks. For example: "they are not aware, they do not live what we live… I'm more intolerant of people" (Physical therapist). The lack of a clear position by Brazilian authorities (Fernandes et al., 2020) and the possible frustration of participants' sense of self-sacrifice seem to relate to these occurrences, as Ardebili et al. (2020) also observed. On the other hand, studies show HCWs perceived greater social recognition, an attenuating factor for psychological suffering (Buselli et al., 2020; Rigotti et al., 2021).

Participants also considered medium and long-term effects: "I worry about the chronic stress that will arise from this" (Nurse) and "it will leave a scar" (Physician). Buselli et al. (2020) and Franklin and Gkiouleka (2021) consider such impacts and recommend immediate interventions to promote the resilience of health teams and systems.

Participants reported leaves of absence due to COVID-19 contamination or stress. One of them considered stop working for some time; another, upon returning from post-contamination leave, said: "I panicked! I freaked out!" (Physician). These situations reinforce warnings by Schmidt et al. (2020) and Teixeira et al. (2020) of the need to care for HCW teams.

Fear and coping

Among the elements that emerged in our meetings, the most intense and unanimous one was fear of contracting COVID-19 and contaminating family members, as several international studies also show (Arafa et al., 2020; Ardebili et al., 2020; Bennett et al., 2020; Buselli et al., 2020; Duarte et al., 2020; Liu et al., 2020; Zhang et al., 2020). A nursing assistant hid among the plants in his backyard and used a garden hose to bathe before entering his home. A nursing technician, infected with COVID-19, had to stay away from her family for a month and a half, whereas a nurse rented an apartment in which she lived alone.

The wife of one of the physicians in our sample moved to another city with their daughter for more than a year: "I didn't see my daughter's tooth erupt," he laments. An English physician reported a similar situation, claiming it had a huge impact on his life (Bennett et al., 2020). Two physical therapists who were contaminated expressed great relief over supposedly becoming immune to the disease and thus, unable to transmit it to their loved ones, in line with what an Iranian physician stated: "if we're going to become infected, it's better to be early" (Ardebili et al., 2020, p. 552).

The same authors also describe participants' guilt and remorse, such as a nurse who stated that if she had another job, her husband would not have died. Such elements corroborate the considerations of Sheraton et al. (2020) and Zhang et al. (2020). This situation represents a violent impact on their home-work interface, configuring psychosocial risk factors at work of a very important magnitude (Leka & Cox, 2008) for at least two reasons. First, because it shows not only a psychological negative work-home spillover on their families (due to HCWs' high stress), but also a concrete one (due to the risk of illness and death). The second reason concerns the lack of family support, which acts as an important attenuator for exhaustion, as Arafa et al. (2020) point out.

Among coping strategies, the most evident one was to try to disconnect from events. Participants avoided watching or coming into contact with the news, which meant creating a space of refuge in their off-duty time. They also sought psychotherapy, support in spirituality, practiced physical activities, and meditated, activities in agreement with Arafa et al. (2020), Granek et al. (2016), and Liu et al. (2020).

The possibility of remote psychological care can be a good alternative in contexts of restrictions and emotional distress such as these (Schmidt et al., 2020). When present, experiences of success and recovery were cited as a source of motivation and resilience. Buselli et al. (2020) and Liu et al. (2020) observed the same, with the caveat that participants' experiences were ambivalent and varied according to patients' conditions.

Despite a few mentions to specific conflicts, most participants, especially nurses, noticed an increase in team cohesion, as well as an improved multidisciplinary perspective permeated by exchange and dialogue. According to the JD-R model (Bakker & Demerouti, 2007), these are examples of resources that enable work to be done, and are in line with the observations in Mojtahedzadeh et al. (2021).

These findings reinforce the adoption of a preventive approach to psychosocial risk management – since this process takes time – in addition to the challenge of integrating professionals used to working with different protocols (Liu et al., 2020). Giménez-Espert et al. (2020) and Sheraton et al. (2020) also value the importance work environments have on the tasks to be performed, especially in an extreme context as such.

Thus, even though death is a recurring theme in hospital scientific literature, the way it has been experienced in this specific context needs to be better understood, as it seems to gain new nuances. In a study by Giménez-Espert et al. (2020) the most evident risk category was emotional work, which implies the effort of having to deal with emotional expression during work. Statements such as "I have to turn cold to keep going and I don't know if doing that is humane" (Nurse) are an example of this sort of stressful demand.

Rethinking life and death

"When you work in a hospital, life and death go hand in hand," said a nursing assistant. However, the number of deaths and how they took place led many participants to make an analogy with a battle. This same professional explains that removing corpses began to make up much of his work: "I carry them on my shoulders!" A Chinese nurse, when describing the entire care protocol, which involved wrapping bodies in several layers of clothing, packed into two bags, and sprayed with disinfectant, states: "It is a little hard to accept this form of death" (Liu et al., 2020). A physician in our sample claims that "living with death is not easy" (Physician), illustrating the statistical data in Giménez-Espert et al. (2020). "It's distressing… the person ends up dying practically alone" (Nurse).

A physical therapist describes, with deep regret, the desperation of patients who asked her not to let them die: "I say I won't, but only few survive." She explains the ethical dilemma of telling the plain truth or trying to comfort patients as best as possible. This type of experience is very close to Benn's testimony (2017) about her deep suffering in the face of a buildup of deaths in a brief period of time.

Death is part of the life cycle, but providing conditions for it to happen humanely requires care and special preparation. The pandemic harshly imposed a cruel contrast with the proposal in Coe (2019), which values patients passing away at home, mediated by specialized caregivers at a time of deep alliance. Several participants were very moved by testimonies of loneliness and family distancing at the time of death, a sorrow also described by Bennett et al. (2020).

Therefore, it is essential to place great emphasis on the approach this theme is to receive in continuous training, team meetings, and development of adequate coping strategies (Granek et al., 2016). In this study, participants sought coping strategies, but they are still incipient in the face of such exhaustion and suffering.

As mentioned, participants are already used to living with death due to their professional experience. However, our meetings allowed us to infer that perhaps death was also differently experienced, and in a more stressful manner, because participants saw it as something unnatural, especially in relation to patients' ages. An indignant nursing technician said: "I see people in their 30s and 40s passing away!," as did an English physician: "And young people!" (Bennett et al., 2020, p. 3).

In addition to the age issue, most participants felt the death of friends and team members as a severe blow, often referred to as something very painful, intense and revolting: "When I found out, I started crying" (Physician). A nurse was dismayed by the loss of a friend: "He was fine! He passed away in a week!" The week before, that same person had invited him to a barbecue. These experiences led to reflections about life and the review of personal values: "our time is short... I will not argue with my mother" (Nurse), in line with the findings of Liu et al. (2020 p. e796): "I cherish life, because I don't know when an accident will happen." "Life is very short and must be enjoyed," concludes one of the nurses in our sample.

This study aimed to understand the experiences of 16 medical, nursing, and physical therapy professionals working on the "front line" of the new Coronavirus. These experiences enabled us to see how participants reacted to the sudden and unexpected arrival of an unprecedented pandemic. They described the progressive physical and emotional exhaustion they increasingly experienced, permeated by technical difficulties, social clashes, and political uncertainty. In general, participants felt that the population's lack of guidance was an important burden in the face of an already incredibly challenging scenario.

Fear, especially of infecting loved ones, was very evident, as was the sorrow from being deprived of contact with them. Participants tried to distance themselves from newscasts, and sought psychological care, physical activity, meditation, and spiritual support as strategies to cope with adversity. More intense contact with death, especially of co-workers, made them rethink what life means, and we noted how sensitized they were about the issue.

Our results also corroborate international qualitative studies, in line with experiences recorded in the United Kingdom, China, Iran, and Germany, and are compatible with data from numerous quantitative studies in Portugal, Egypt, Spain, England, China, and Iran. The set of information on different coping strategies is coherent in portraying a global phenomenon.

We should consider the limitations of our methodological design. The content produced is not intended to be generalizable because it does not derive from statistical population samples. However, it comprised a multicenter effort and involved two reputable regional hospitals in different Brazilian regions. Moreover, the careful, balanced, and representative composition of the group of participants ensured the robustness and quality of our findings. Regardless of locality, function or gender, the great affinity between the reported experiences draws our attention even when we compare them with international studies.

Among the main contributions of this study, we can highlight two additional ones. First, it is evident the importance that psychosocial risk factors at work and the respective balance between work demands and resources have on the quality of life of HCWs working in this peculiar context of a pandemic. Second, this study innovates by adopting a phenomenological method to Work Psychology, allowing participants to play a greater role in co-creating scientific knowledge from their intersubjective relationship with researchers.

It is essential to watch over the psychosocial environment of work, understanding it and enabling resources at its different levels: contextual, institutional, group, and individual. Public policies based on scientific knowledge must form the basis of the entire national health system, and cannot be entangled with ideologies or political interests. Information campaigns, definition of protocols, and the acquisition of inputs and vaccines are fundamental resources which need to come from national strategies. Otherwise, the physical and mental health of frontline professionals is put at risk.

At the institutional level, hospitals are responsible for defining care guidelines and protocols, as well as providing their employees with work resources (e.g., protective equipment, training, communication, social support, and leadership). The absence of some factors, such as requiring HCWs to wear masks, was a component that generated conduct ambiguities and stress for participants.

At the group level, the need for social support and strengthening teamwork proved essential. Moreover, amplifying interdisciplinarity, communication, and relevance of the entire team, giving voice to all professionals, proved to be fundamental, since some participants reported not having been heard. Finally, but as important as the other intervention levels, contemplating strategies to strengthen personal resources (e.g., resilience and self-care) becomes essential. Individual or group formal support strategies are support factors which concretely indicate concern with the health and well-being of those who care.

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